FLORIDA TECH

REQUEST FOR LEAVE OF ABSENCE

Employee name ______________________ ID number ______________________

Department ______________________ Supervisor ______________________

Date of hire ______________________ Employee phone number ______________________

I request permission for a leave of absence during the period:

From (date) ______________________ To (date) ______________________

Purpose of leave:

I acknowledge:

1. I have read and understand the Florida Tech Leave of Absence Policy and agree to abide by the policy.
2. I understand that I must make arrangements with the Office of Human Resources for my part of the insurance coverage costs prior to the beginning of the leave. If I fail to return to work at the expiration of the leave of absence, I will repay the share of my insurance coverage not paid during the leave of absence.
3. I understand that unless prior arrangements are made for an extension, if I fail to return to work at the expiration of the leave, my employment will be deemed to have been terminated as of the original termination date of the leave.
4. Medical certification is necessary to return to work if the leave request is for the employee's health condition.

NOTE: An employee on leave of absence will not accrue vacation or sick leave and will not be entitled to holiday pay.

❑ I have exhausted or do not qualify for FMLA.
❑ This request is part of my request for a reasonable accommodation.

Employee signature ______________________ Date ______________________

TO BE COMPLETED BY DEAN, DIVISION DIRECTOR, DEPARTMENT HEAD OR PROGRAM CHAIR:

❑ Approved—normal work load of this employee will be covered as follows:

❑ Not approved—reason:

Supervisor signature ______________________ Date ______________________

Dean/VP signature ______________________ Date ______________________

OFFICE OF HUMAN RESOURCES USE ONLY

Employee position number ______________________ Approved ______________________ Date ______________________

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